STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY  DEPARTMENT OF ALCOHOL AND DRUG PROGRAM														GRAMS				
Media Type (ch	eck one)	MONTH	LY CLAIM	FOR D	RUG/ME	DI-CAL	REIMBU	IRSEME	NT	Check one								
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TAPE/DISK SUPPLEMENTAL						MONTHLY PROVIDER SERVICE AND REVENUE SUMMARY DIRECT CONT.												
	PARADOX DISK CalWORKs														PAGE	OF		
	INTERNET - PARADOX	_																
COUNTY	INTERNET - E-MAIL			COUN	TY CODE CLAIM FOR MO/YR				CONTRACT # PROGRAM CODE (che				ck one)			FISCAL YEAR	,	
33311									<b>3</b>		[ ] 20 (Alc/Drug) [ ] 25 (					TIOOAL TEAN	ı	
BATCH#				\$ AMOUNT				\$ ADJUSTMENTS TO			25-101)	(	(25-102) TOTAL \$/CENTS		/ NET			
State Use PROVIDER NAME					UNITS	\$ AMOUN CLAIME		RF\	REVENUE BY SOURCE		ADJUSTM					CLAIM		
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COUNTY (	CERTIFICATION this t	orm hove h	oon poroonally pro	wided to	the netiont by	the provider	or under h	io direction	by anothor	r noroon oli	aible unde	rtho Madi Ci	al Brogram	to provide cue	h conuc	oc and allah n	oroon/o	
are designate	d on this form. The serv	ices were, t	o the best of the p	rovided to	knowledge, m	nedically indica	ated and r	necessary to	o the health	n of the pati	ent. The p	rovider unde	erstands tha	it payment of t	his clain	n will be from	315011(5	
ICERTIFY the services listed on this form have been personally provided to the patient by the provider or under his direction by another person eligible under the Medi-Cal Program to provide such services and such person(s are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services turnished to the patient. The provider agrees to turnish these records and any information regarding payments claimed for providing the services.															te of			
on request, to	California Department o	of Health Se	rvices; Medi-Cal F	raud Unit	, California D	epartment of J	Justice; M	edi-Cal Aud	dits Project	, Office of S	tate Contr	oller, U.S. De	epartment o	t Health and H	iuman &	Services, or the	ir duly	
authorized rep												lia a la ilui					-	
Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.																		
SIGNATURE: DATE: EXECUTED AT:																		
	NTRACT PROVIDE	R CERTIF	ICATION															
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claim is in all	I CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Program services in and for said claimant; that I have not violated any of the provisions of Sections 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with the law.    DATE:																	
SIGNATUR		PACT PROVI	DER ADMINISTRATO	ıP					DATE:_			EX	ECUTED	AT:				
COUNTY/D	<b>IRECT CONTRACT I</b>	PROVIDE	R															
I CERTIF	Y under penalty of	perjury	that I am the	duly q	ualified ar	nd authoriz	zed offi	cial of th	ne hereiı	n claima	nt respo	onsible fo	r the exa	amination	and s	ettlement c	of acc	
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	SIGNATURE CAR																	
ADP 1592 (Re	v.7/99)	***** NOTE	!! SIGNATURES AF	RE REQUIF	RED ONLY ON	THE GRAND TO	TAL PAGE	****			G:\GROUP	S3\FM\123DAT	A\MCFORMS	CURRENT1\15	92 Rev 7	/99		

## Completion instructions for ADP 1592

Revised 7/99

#### THIS FORM SHOULD BE USED FOR BOTH THE COUNTY AND THE DIRECT CONTRACT PROVIDERS

#### I. GENERAL

The ADP 1592 - MONTHLY CLAIM FOR DRUG/MEDI-CAL REIMBURSEMENT AND MONTHLY PROVIDER SERVICE AND REVENUE SUMMARY is used for reporting total Drug/Medi-Cal units of service, total dollar amount claimed, total revenue collected/reported by source, claim adjustments and the net claim amount by provider.

#### II. HEADING INSTRUCTIONS

- a. Media Type check the type of media on which the claim is being submitted.
- b. Type of Submission check the type of claim being submitted. Only Internet Paradox or Internet E-Mail claims should use Submission Types Resubmission or Rejected.
- c. Check the type of claim being submitted whether by the County or the Direct Contract Provider.
- d. County enter name of county submitting claim
- e. County Code enter the two digit county code
- f. Contract # enter the Direct Contract Provider Number (for DIRECT CONTRACT PROVIDERS ONLY).
- g. Claim for Mo/Yr enter month/year in which the claim is being submitted.
- h. Program Code check the appropriate box for Drug Services (20) or Perinatal Services (25)
- i. Fiscal Year enter fiscal year of service
- j. Date enter the date this form was completed
- k. Page/of enter each page number and total of pages (i.e., page 1 of 9)

### III. COLUMNAR INSTRUCTIONS

- a. Provider Name enter name of program providing services. If Direct Contract Provider enter the provider name.
- b. Provider Number enter the four digit provider number assigned by the Department of Alcohol and Drug Programs
- c. Service Function Code (SFC) enter the two digit SFC; 20-22= Methadone Dose, 23-25 = LAAM Dose, 26-27=NTP Individual Counseling, 28-29=NTP Group Counseling, 30-39=Daycare Habilitative, 40-49=Perinatal Residential, 50-59=Naltrexone, 80-84=Outpatient Drug Free Individual Counseling, 85-89=Outpatient Drug Free Group Counseling.
- d. Units of Service for each service function code, determine and enter the units of service rendered or reported by each provider for the claim month
- e. Amount Claimed for each service function code, determine the total dollars, including cents, incurred or reported by the provider for the claim month.
  - NOTE!! ALL INCURRED OR REPORTED DOLLARS BILLED MUST BE SUPPORTED BY THE ADP 1584 DRUG/MEDI-CAL FLIGIBILITY WORKSHEETS
- f. Adjustments to the Gross Claim: REVENUE for each service function code and each provider, determine and enter the total revenue collected or reported during the claim month by revenue source. REVENUE SOURCES NOT LISTED ON FRONT MAY BE REPORTED UNDER THE "OTHER" COLUMN AND \$ AMOUNT ENTERED. The revenue not listed on front is: Grants, Adjustments - enter adjustments by provider. (only deduct current FY adjustments)
- g. Total Revenue Adjustments enter total of both revenue and adjustments. (Should never show a negative \$ amount).
- h. Net Claim net claim equals amount claimed, minus total revenue and/or adjustments.
- i. Page Totals enter column totals for units of service, amount claimed, total revenue and/or adjustments and net claim.
- j. Grand Totals on the last page of the monthly invoice, enter the grand totals of amount claimed, total revenue and/or adjustments and net claim.
- IV. County Fiscal Representative or Direct Contact Provider Representative the signature and phone number (including the area code) of the responsible county/contractor representative for contact purposes.
- V. CERTIFICATION STATEMENTS sign the appropriate certification statement.
  - a. COUNTY CERTIFICATION the signature of the County Alcohol/Drug Program Administrator (FOR COUNTY ONLY)
  - b. DIRECT CONTRACT PROVIDER the signature of the Contract Administrator (FOR DIRECT CONTRACT PROVIDERS ONLY).
- VI. FISCAL OFFICER signature of the County Auditor Controller or Finance Officer, or the Direct Contractor Finance Officer (FOR BOTH COUNTY AND DIRECT CONTRACT PROVIDERS).
- VII. Check the box if the ADP 1592 does not have signatures and a signature card is on file with ADP.

NOTE: THREE ORIGINAL SIGNATURES ARE REQUIRED ON THE ADP 1592. SIGNATURES ARE REQUIRED ON ANY PAGE ON WHICH A GRAND TOTAL IS ENTERED.

# **VIII. SUBMISSION INSTRUCTIONS:**

- 1. The original Eligibility Worksheet (ADP 1584).
- Original Adjustments by Provider form (ADP 5035 Rev.) with original signatures, and two copies (if adjustments are made to this month's claim).
- Original Monthly Claim for Drug/Medi-Cal Reimbursement (ADP 1592) with original signatures and three (3) copies.

# MAIL TO:

Department of Alcohol and Drug Programs Drug/Medi-Cal Section 1700 "K" Street Sacramento, CA 95814-4037

ADP 1592 (Rev. 7/99)

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